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ABSTRACT

The concept of "mothercraft" can be influenced by the sociocultural environment and the individual mother and her attributes. This study examined the differences in mothering between those who live in urban areas and those who live in rural areas. Although the study drew on work currently in progress on the relationship between mothering and infant health, the focus was on the mother's characteristics and her social setting. Both an urban and rural sample were chosen, using the resources of the City of Milwaukee Department of Health and the county public health nurses of 4 Wisconsin nonmetropolitan counties. The nurses selected families with whom they had had some prior contact, who had had a baby within the past 3 months, and where the mothers were willing to be interviewed about themselves and their baby's health. Data were obtained through interviews with 101 mothers in Milwaukee and 47 in the rural areas and from the nurses' observations and evaluations. Some findings were: there was more of a tendency to have "traditional" family patterns such as being married, going to church, and running a home with more regular schedules for the baby's eating and sleeping patterns in rural areas; the rural nurses evaluated their mothers higher on quality of mothercraft than did the urban nurses; and there were no differences in the utilization of medical services. (NQ)

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The Concept of Mothercraft as Related to Infant Health in Urban and Rural Settings

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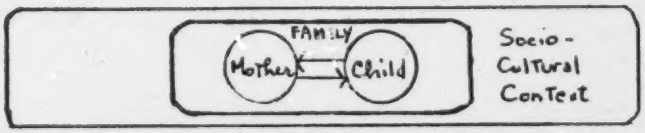
THE CONCEPT OF "MOTHERCRAFT" AS RELATED TO INFANT HEALTH IN URBAN AND RURAL SETTINGS

I. Introduction

The likelihood of a baby's proper growth and development depends on a myriad of factors. One essential factor is the mother's care and attention to the baby. Conceptually, we can think of the mother-baby dyad as a basic nucleus, embedded in a larger system, the family.



This unit, however, is also located in a larger system, which for our purposes here we will term the "sociocultural context." In the socio-cultural context, we include relationships with important secondary groups in the life of the mother as well as the social institutions available for her use (health clinics, school, churches, clubs and organizations, etc.)

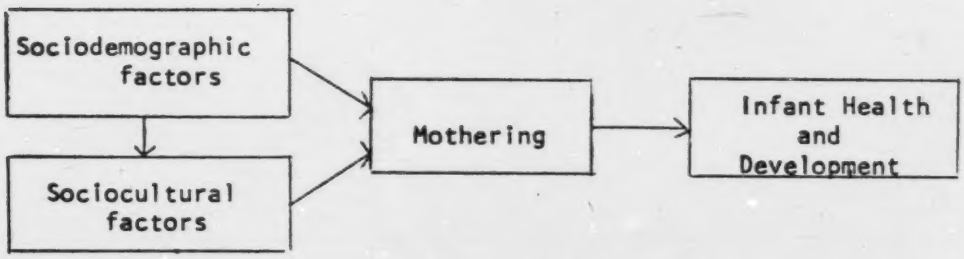
Previous research on infant health and development has primarily been concerned with diet and health care of the child. Some attention has also been focussed on mother's psychological and personality states, especially when of an extreme type.* What this research hopes to address is the importance of the sociocultural setting of the family and the effects it may have on mothering ability.

The focus of this paper will be to ferret out any differences which may be present in two different types of sociocultural settings: one, an inner-city area of a large metropolitan area, the other more isolated locations in sparsely settled rural areas.

The concept of "mothercraft" has various components, and I suggest that some of these components are under the domain of the mother, and thus will not vary by rural-urban setting. These include personality of the mother, health attitudes and beliefs, physical care of the child, and emotional handling of the child. There are other aspects of mothering which depend more on the external setting, and thus they will be more likely to vary by rural-urban location. Examples of these are: physical environment, health care of the child, health knowledge of the mother, and traditional family patterns.

* Thomas et al., 1968

These variables will be examined in the following model:



I plan to examine the components of mothering, and note the differences among the two groups of mothers, those who live in urban areas and those who live in rural areas.

This paper draws on work that is currently in progress on the relationship between mothering and infant health. For this discussion, however, we will not be examining the development of the infant -- but rather focussing on the characteristics of the mother and her social setting.

II. Source of Data

The data for this paper are drawn from a study of "Mothercraft as Related to Infant Health" which started about one year ago. Both an urban and rural sample were chosen, using the resources of the City of Milwaukee Department of Health and the county public health nurses of four Wisconsin nonmetropolitan counties. (See Map I for location of study families and general hospitals.) The method of selection varied in the two settings. In Milwaukee, with the cooperation of the public health nurses, I was able to screen from the list of all births a subset of homes where the quality of "mothercraft" was likely to be poor. This was done through an initial screening home visit by the nurses, after a training session on the purpose of the research. I selected health districts in Milwaukee where many low income families live. The nurses were asked to choose families with whom they had had some prior contact, who had had a baby within the past 3 months, and where mothers were willing to be interviewed about themselves and the health of their babies. One hundred and one Milwaukee families were chosen and interviewed by ten nurses.

A somewhat similar procedure was followed in four nonmetropolitan counties of Wisconsin. The cooperating county nurses were given the same training and instructions as the Milwaukee group. Screening was more difficult, however, because of the severe shortage of health personnel in those areas. In the rural areas, a total of 16 nurses were trained, and each volunteered to find 3 babies each. Even this number proved difficult. The county health departments by and large do not provide pre or post natal care, or any maternal and child care unless it falls within the specific categorical aids programs. Thus, with the declining birth rate, and the common exodus of young adults in rural areas, the birth of an infant was a rare event. In addition, the nurses had no access to information about those who were born, except for the birth certificates and occasional referrals from social service departments or medical sources. However, 47 babies were located.

Table 1 presents some comparative figures for Wisconsin, the City of Milwaukee, and the four rural counties chosen for research sites. The four rural counties represent different types: Wood and Marathon have larger populations, with a number of cities over 2500 included. The other two, Clark and Waushara, are almost totally rural, have more aged in the population and lower birth rates. Their medical facilities are meagre, and are located at a sizable distance from the residents. Wood county, on the other hand, contains an established and well known group medical practice, the Marshfield Clinic, which is a resource for the residents of the area as well as for those living a considerable distance away. The City of Milwaukee is distinguished in this group for its large population, high density, and larger proportion of nonwhites. As with most large metropolitan areas, it has ample medical facilities and doctors, including pediatricians. The study families all live in close proximity to hospitals and physicians.

Nurses interviewed the mothers with a standardized schedule, then weighed and measured the baby, and administered the DDST. The latter is a developmental screening test which taps four areas of growth: fine and gross motor skills, language ability, and personal-social skills.

Some demographic background characteristics of the babies and mothers chosen are presented in Table 2. Surprisingly, there are only a few differences among the two groups:

1) Race. 70% in Milwaukee are black; none in rural areas. This reflects the different racial composition of the poor in rural and urban areas, although blacks are overrepresented in the Milwaukee group. In 1970, about 40% of the poor families in Milwaukee were black.

2) Marital Status. 35% of the Milwaukee study mothers are married compared with 75% of the rural families. This is also reflected in the fact that 41% of the urban and 79% of the rural households have fathers of the baby present in the home.

None of the other background characteristics vary significantly by residence, except for public assistance. In urban areas, it appears that a larger proportion of the study families get assistance than rural ones. Additional computations were made, controlling on the income distribution. In every case, the differences for ADC payments and Food stamps remained significantly higher in the urban group; however, approximately the same proportion of urban and rural families received medicaid, when the effect of income was controlled.

We have not yet classified the families by poverty status, which takes into account both family income and family size. Because the household size is somewhat larger in Milwaukee, we anticipate a greater effect of the income differences appearing with this new index than appears here with income alone.

It should be noted that the research design is a longitudinal one, where these families will be followed until the infant reaches 18 months.

III Components of Mothercraft

The concept of mothering can be thought of as including two different levels of inputs:

I. the sociocultural environment

II. the individual mother and her attributes.

Both these inputs create the output of "mothering" to an infant.

Another way of saying this is that some inputs are external to the mother-child dyad and others are within the dyad itself. An example of the former would be the medical resources available to the mother if she chose to use them; an example of the latter might be the mother's personality characteristics.

In this paper I have chosen the following to represent these areas:

I. Variables measuring the sociocultural environment

A. the physical environment*

B. Utilization of existing medical resources

C. Social isolation or integration into a larger family and community network

D. "Traditional" family patterns

II. Variables measuring characteristics of the individual mother and her personality attributes

A. Personality of the mother*

B. Emotional and cognitive handling of the child*

C. Physical care of the child*

D. Mother's attitudes toward preventive care and using medical facilities.

Previously we suggested that urban-rural settings would affect the sociocultural environment, not the individual attributes of mothers. Therefore, we suggest that there will be significant differences in variables mentioned in Part I, above, but not Part II.

*Measured by nurse's observations and evaluations.

Some of these areas were operationalized by asking the mother specific items of information during the interview. Others, however, had to be gleaned from observation and evaluation. These are noted above with an (*), and perhaps require some additional explanation.

The evaluation of physical environment was conducted by the nurses after interviewing the mother and leaving the home, by filling out a detailed checklist of specific items such as a set of questions on housing and plumbing conditions, overcrowding; cleanliness and safety conditions in the home, and material attributes available such as bedding, a minimal level of furniture, toys, magazines, books, etc. Personality of the mother was tapped by items on three aspects of personality that in previous research (Polansky, 1972) have shown promising relations to child neglect: dependency, apathy-futility, and verbal expression and communication with others. Emotional and cognitive care of the child was evaluated by a set of questions on "handling" by the mother, including physical touch, warmth, and cognitive stimulation through playing with the child. Physical care of the child was measured by questions on cleanliness and dress, adequate clothing, rest patterns and feeding patterns. Concern with medical care of the child was also included.

In addition, the nurses were instructed to provide a summary evaluation of the mother's performance. Because of the difficulty of weighing the relative importance of providing good physical care to the child vs. emotional warmth and personal attention to the baby, the nurses requested that these two aspects of mothercraft be evaluated separately. Thus the mothers were rated as to "good instrumental care" (i. e., taking care of the child's physical needs) and "mothering" (concern for the child and emotional and cognitive care).

Keeping in mind the somewhat selective nature of the sampling procedure, Table 3 shows the ratings of the nurses of the urban and rural samples. We note that even with the attempt to maximize the cases of poor mothercraft, we get almost no mothers rated "very poor," And in the rural sample, almost half the mothers are rated "very good." This difference will be running through the discussion below.

Utilization of medical resources was scored by a series of questions answered by the mother on recency (if ever) of a well baby checkup and immunizations for the child; and for herself, month of first prenatal visit, postpartum checkup, and the recency (if ever) of a general physical, visit to the dentist, and pap smear. Social integration was measured by church attendance, belonging to clubs frequency of visiting relatives and friends, frequency of going out for eating, drinking, or seeing a movie, and reading a newspaper regularly. Certain "traditional" family patterns were evaluated: 1) whether the mother was married; and 2) whether the baby had regular eating and sleeping schedules.

The mother's attitude toward using preventive care is based on her responses to four questions in the interview, such as getting a checkup once a year, seeing a doctor when nothing is physically wrong, etc. Her attitudes toward using the medical system were tapped by a series of questions such as, "Would you be likely to consult a doctor if you had a temperature of 103^0 for two days", and other symptoms (Mechanic and Volkart, 1961). Unfortunately, I did not anticipate the amount of "yeah-saying" to these questions just because a uniformed representative of the medical system was asking the questions. So these questions are not useable and we have revised the series for the second interview with the mother.

IV Findings

Table 4 summarizes the evidence in these eight areas. Looking first at Part I, we note that the appraisal of the physical environment of the homes of the urban and rural families are somewhat different, with the urban families having greater numbers of negative aspects noted (3.9 compared with 2.3 items out of 21 possible negative items). Utilization patterns appear to show no differences at this point in the life of the mother and infant. Both groups appear to be getting about the same level of care. [Parenthetically, we might note that both the rural and urban nurses in feedback sessions commented that these findings were not unanticipated. Health care is recent when a baby is so young and childbirth so relatively close in time. The nurses expect much less use of the medical system when they return to the homes when the infants are turning one year old. Childbirth is one time in the U.S. when a mother

and infant are literally forced to have medical care in a hospital setting, and thus are captives for checkups and examinations.]

Parts of the social integration concept appear to be different in the urban and rural areas. Church attendance is more frequent in rural families; perhaps another indication of traditional family patterns. Belonging to clubs and organizations is also more frequent. When, however, an index was constructed of all items which pertain to social integration, the differences between the two residential samples no longer was significant.

Mother's marital status also turns out to be quite different in the rural and urban homes selected for study. Rural mothers are much less likely to be single than the urban mothers. There is also a tendency for rural mothers to keep their babies on regular schedules for eating and sleeping more than the urban mothers.

To summarize, then, we see some evidence suggesting the physical environment is better in rural homes; there is more of a tendency to have "traditional" family patterns such as being married, going to church, and running a home with more regular schedules for the baby's eating and sleeping patterns. On the other hand, there seems to be no difference in utilization of medical services; in fact, in both groups the figures appear to be somewhat high. This, we suggested, may be due to the time they were interviewed (shortly after the birth of a baby), rather than a life long pattern. At any rate, the lack of accessibility to medical care, which we know varies by location, does not seem to affect the utilization patterns at this time.

Turning now to individual characteristics, the mother's personal attributes, where we expect no differences due to rural-urban location, we see two areas where this does not seem to be the case. First, in the appraisal items on mother's personality (dependency, apathy-futility, and verbal communication), we note a difference in scores, with urban mothers having more negative items checked. Closer analysis of these scores (not presented here) indicates that the items are more frequently checked in the "verbal" aspect, which taps the mother's inability to express her emotions, to verbalize her feelings, and to communicate her thoughts. The second area where significant rural-urban differences

appear, physical care of the child, contains items on cleanliness and dress of the infant, rest and feeding patterns, and medical care. Here we see reflected the lack of schedules for the urban sample. There is no difference between the urban and rural groups on the cleanliness component or the medical care component.

The emotional handling and stimulation of the infant shows no difference between the urban and rural sample, nor do any of the indices of attitudes toward preventive care or propensity to seek care for herself or her child.

To conclude, we have noted one area in Part II where the groups of rural and urban mothers are quite different: that of verbal communication. The other difference, that of physical care, we suggested was explained by the rest and feeding pattern differences mentioned above.

We now turn to an examination of the relative importance of these various components as they are affected by background characteristic of the mothers, using as the dependent variable quality of mothercraft.

Multivariate Analysis

In this section, we present results using all of the components of mothercraft mentioned above. In addition, we include education of the mother and family income as socioeconomic inputs, and number of living children born to the mother, because of some research which indicates high parity children get less medical utilization, in order to assess the importance of the various components in the ratings of mothercraft made by the nurses.

Table 5 shows the correlations of these variables with the two aspects of mothercraft: good instrumental care and mothering. Looking first at the total group, we see significant relationship with education, income, and marital status. The urban-rural classification also is significantly related to mothercraft. We noted above that quite consistently, the rural nurses evaluated their mothers higher on quality of mothercraft than did the urban nurses. We cannot answer the question whether the sample chosen was of better mothers, whether the nurses are using different criteria, or whether there is in

actuality a different quality of mothering in urban or rural areas. We are inclined to believe after talking with the nurses it is the first possibility: the sample of mothers chosen was different.

Social integration also appears to have a significant relationship with the mothercraft evaluations for the total sample.

Turning to a comparison of the urban and rural groups, they seem to differ somewhat when we compare the significant components within them. All three scoio-demographic variables appear important for the urban group, two measures of medical utilization, the baby physical for instrumental care, and early prenatal visits for the mothering score appear strong. No utilization measures are significant in the rural group. Instead, the mother's attitude toward preventive care appears to be related to good instrumental care.

The lower bank of correlations show the relationship of each of the appraisal components with the summary scores of instrumental care and mothering. (The correlations are negative because the appraisal scores are based on total number of negative items.)

Almost without exception, physical environment and treatment of child are more highly correlated with good instrumental care than mothering. And the emotional and cognitive care and mother's personality are more highly correlated with the mothering rating. This is as was to be expected, given the nurses instructions for rating.

Our final step is to put these variables into one equation in order to see the total explanatory power of the model as well as the variables which are significant contributors controlling for the other variables in the model. Table 6 presents this data.

The amount of variance explained in Model 1 varies (without including appraisal scores) from about 27%to 37% for good instrumental care to about 25% for mothering. Adding the appraisal scores (Model 2) increases the amount explained to around 55% for good care and 58% to 67% for mothering. Clearly, the appraisal scores add more explanatory power in the equations relating to mothering when compared with instrumental care.

Table 6 also lists the variables in these total equations which have partial correlations significant at the .05 level. Looking first at the total group, we see most variables drop out, leaving marital status and education for both dependent variables, and getting the baby a physical for instrumental care. Adding the appraisal scores (Model 2) changes the picture somewhat. For instrumental care, emotional/cognitive care and physical care are extremely important, and only marital status from the sociodemographic and sociocultural group remains important. For mothering, marital status is replaced by education (For the reader's information, Appendix A contains the zero order correlation matrix among all the variables for the total group.)

Now looking at the urban and rural mothers separately, a few interesting contrasts emerge. In general, income seems to explain more in the urban group; mother's education in the rural one. (We are currently examining the income variables, because we feel that earned income or public assistance in the city may have quite a different meaning than reported family income in the rural areas.) In Model 1, two measures of utilization appear in the urban group; none in the rural, while the mother's expressed attitudes toward preventive care is related to the baby's instrumental care rating in the rural areas.

As for adding the appraisal items (Model 2); the emotional/cognitive care is important in all ratings. Physical care is important in the good instrumental care rating, and mother's personality in the mothering rating.

V. Discussion

What story do we see emerging from this body of data? Two factors run through all families, regardless of location. Education of mothers seems to be important in both rural and urban settings. Emotional and cognitive care given by mother is also important regardless of location. Physical care appears more highly related to instrumental care, while mother's personality is related to "mothering".

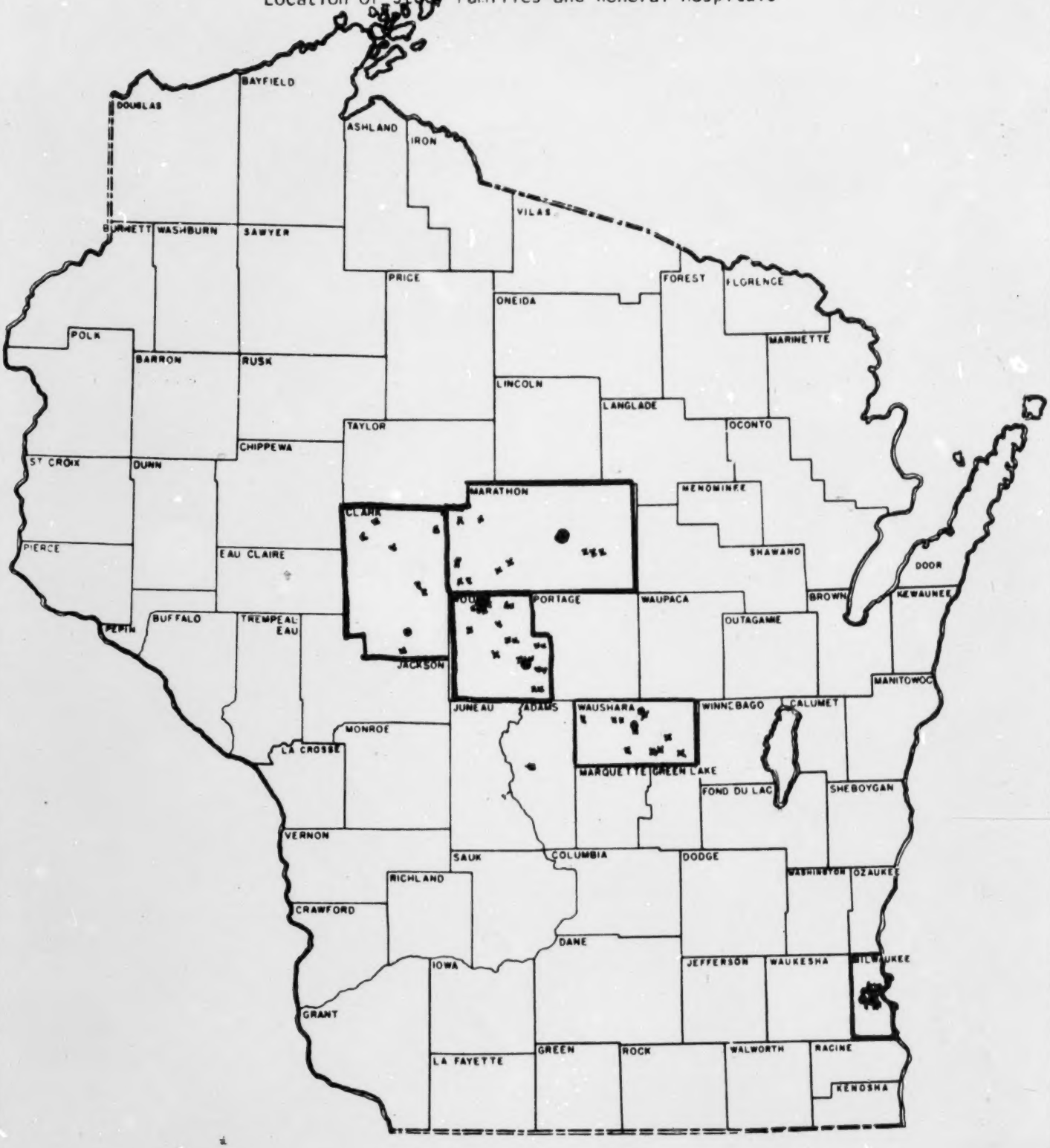
While we noted some differences in background characteristics (marital status, social integration, regular eating and sleeping patterns) at the beginning of this paper, when we relate these variables to the quality of mothercraft, they do not appear, but what does

emerge are characteristics within the groups. Mothers with better education are rated better on instrumental care and mothering; mothers with more positive attitudes toward getting preventive care are also rated higher on mothercraft scores. The variables of actually using medical facilities at this point appear to be more highly related in the urban sample, probably because the rural mothers by and large reported getting more medical care.

In conclusion, this exploratory research is exactly that. The data leave us with innumerable questions to ask, and many choices of paths to follow. Fortunately, we are now in the field conducting the next set of interviews, now that the babies are turning one year old. We anticipate more diversity amongthe mothers, more variability in their use of medical facilities, and more indications of poor mothercraft now that the infants are toddlers, and demanding attention and affection from their mothers.

Map 1

Location of Study Families and General Hospitals



× Study families
● General Hospital

Table 1

Population Characteristics and
Summary of Health Facilities in Four Selected Wisconsin Counties
and the City of Milwaukee

	WISCONSIN	MILWAUKEE CITY	WOOD	MARATHON	CLARK	WAUSHARA
Total population (1973)	4,569,000	693,000	67,200	101,616	31,273	15,480
Density (1970) per sq. mi.	83.9	7,551.3	83.2	64.1	25.6	24.7
Age distribution (1970)						
Less than 18	35.8%	32.8%	39.3%	37.8%	38.2%	33.0%
18 - 64	53.4	56.2	50.6	52.1	47.2	49.9
65+	10.7	11.0	10.0	10.1	14.3	17.1
Urban-Rural Distribution (1970)						
Rural non farm	23.2%	0.0%	36.1%	32.2%	47.7%	67.6%
Rural Farm	10.9	0.0	11.7	18.2	43.2	32.2
Urban	65.9	100.0	52.2	49.6	9.1	0.3
Crude Birth Rate (1972)	14.3	16.3	15.2	14.5	13.7	13.4
Mean Persons/Household	3.2	3.0	3.4	3.4	3.4	3.0
Nonwhite (1970)	3.6%	15.6%	0.5%	0.2%	0.3%	0.3%
Families below poverty	7.4%	8.1%	7.5%	8.3%	14.1%	12.7%
No. of general hospitals	149	21*	2	1	1	2
No. of beds/1000 population	5.4	6.2	8.4	3.9	2.1	4.6
No. of active physicians	5,615	1887	132	80	14	8
Rate/1000 population	1.2	1.8	1.8	0.7	0.5	0.7
No. of pediatricians	299	64	6	2	0	0
Total no. of study families	148	101	21	10	7	9
No. of study families within 10 miles of a hospital	-	101	21	7	0	6

*County Figures

Sources: Wisconsin Physicians: Description, Distribution, 1973. Division of Health Wisconsin Department of Health and Social Services, January 1975. Madison, Wi.
Socioloconomic Data and Change Measures for 1970 and 1972.
Center for Social Research and Development. Denver Research Institute.
University of Denver, Denver, Colorado. March 1975.
1970 U.S. Census of Population. Wisconsin PC(1) B51. General Population Characteristics.

Table 2

Selected Background Characteristics of Urban and Rural Sample

	URBAN (N=101)	RURAL (N=47)
Baby		
Sex		
Male	50	23
Female	51	24
Birth Weight		
Less than 5 1/2 lbs.	9%	11%
5 1/2 - 8 1/2 lbs.	80	70
8 1/2 lbs or more	11	18
Mean Age at Interview	3.0 months	3.9 months
Mother		
Age		
Under 18	25%	25%
18 or older	75	75
Mean age	21.8	23.3
Race*		
Black	70%	0%
White	27	87
Other or N.A.	4	15
Mean number of siblings	5.7	5.2
Mean household size	5.4	4.6
No. of living children		
One	35%	53%
Two	30	19
Three	8	4
Four or more	15	11
Mean number	2.5	2.3
Marital Status*		
Married	35%	75%
Not married	65	25
Household composition		
Mother with baby (+ children)	34%	13%
Mother, Father with baby	35	66
Mother with baby + extended family	26	9
Mother, Father with baby + extended family	6	13
Father present in household	40%	74%
No. with additional female 16 years or older in house besides mother	25%	24%

Table 2, continued

	URBAN	RURAL
Education		
Elementary or less	10%	11%
Some high school	58	40
High school grad	24	38
College	8	11
Family Income		
Less than $3,000	20%	26%
3 - 5,000	45	28
6 - 8,999	21	26
9 - 11,999	9	13
12,000 +	5	9
Median Income	$5500	$5500
% receiving public assistance		
Food Stamps*	56	31
AFDC or ADC*	66	34
Medicaid*	70	53

* Urban and rural groups are significantly different at < .05 level.

Table 3

Ratings of "Good Instrumental Care" and "Mothering"

	Good Instrumental Care		Mothering	
	Urban	Rural	Urban	Rural
Very good	15	45	14	47
Good	57	53	56	30
Somewhat Poor	25	2	27	21
Very Poor	3	0	3	2
NA				1*
Total %	100	100	100	100
N =	101	47	101	47

* Less than one percent

Table 4

Urban Rural Differences in Aspects of Mothering

	URBAN	RURAL
I. Sociocultural Variables		
A. Physical Environment* (nurse's appraisal with 21 items)		
Range	0-15	0-12
Mean number of negative items	3.9	2.3
s.d.	3.4	3.0
B. Utilization of Medical Facilities		
Baby received checkup	83%	89%
Baby received immunizations	58	53
Mother visited doctor in 1st trimester of pregnancy	61	74
Mother had postpartum checkup	77	87
Mother had general physical within a year*	19	30
Mother had dental visit within a year	43	49
Mother had pap smear within a year	86	83
C. Social Integration		
Mother goes to church once a month or more*	40%	65%
Mother belongs to a club or organization*	9	23
Mother visits friends and/or relatives once a week or more	56	61
Mother goes out for eating, drinking, or seeing a movie once a week or more	21	26
Mother reads newspaper regularly	56	48
Integration Index (Range 5-25)		
Mean	14.1	15.6
s.d.	3.7	4.6
D. "Traditional" Family Pattern		
Mother single*	53%	17%
Baby has regular schedule for eating	69	85
Baby has regular times for sleeping	74	89
II. Mother's individual attributes		
A. Personality ** (nurse's appraisal with 21 items)		
Range	0-14	0-12
Mean number of negative items	4.1	2.9
S.D.	3.3	2.9

	URBAN	RURAL
B. Emotional and Cognitive Care of Child* (nurse's appraisal with 14 items)		
Range	0-12	0-9
Mean number of negative items	3.7	2.6
S.D.	3.3	2.4
C. Physical Care of Child* (nurse's appraisal with 21 items)		
Range	0-14	0-10
Mean number of negative items	3.2	1.8
S.D.	2.8	2.3
D. Health attitudes of mother		
1. Preventive care (index of 4 questions in interview)		
Range	0-4	0-4
Mean number of negative items	2.6	2.4
S.D.	1.0	1.1
2. Propensity to seek care for self (3 items)		
Mean	6.6	6.6
S. D.	2.0	1.8
for child (4 items)		
Mean	3.7	3.3
S. D.	0.6	0.9

* Significantly different at $<.05$ level.
** Significantly different at $<.10$ level.

Table 5

Correlations between Background Variables, Medical Utilization, Health Attitudes, Social Integration, and Mothercraft

	TOTAL (N=148)		URBAN (N=101)		RURAL (N=47)	
	Instrumental Care	Mothering	Instrumental Care	Mothering	Instrumental Care	Mothering
Background Characteristics						
Education	.365*	.356*	.289*	.273*	.492*	.428*
Income	.291*	.285*	.315*	.324*	.305*	.236
Marital Status	.423*	.361*	.343*	.353*	.283	.204
Number of Living Children	-.089	-.002	-.161	-.045	.099	.087
Medical Utilization						
Baby physical	-.204	-.086	-.238*	-.099	-.016	-.005
Mother physical	-.126	-.120	-.068	-.112	-.111	-.044
Prenatal visit	-.158	-.163*	-.191	-.238*	.120	.089
Attitudes toward						
Preventive Care	.147	.151	.145	.137	.337*	.247
Social Integration	.246	.249*	.219*	.184	.174	267
Urban/Rural	.385*	.246*				
Appraisal Scores						
Physical Environment	-.551*	-.500*	-.556*	-.472*	-.392*	-.484*
Treatment of Child	-.539*	-.474*	-.532*	-.454*	-.389*	-.440*
Emotional/Cognitive	-.523*	-.640*	-.523*	-.637*	-.429*	-.656*
Personality	-.431*	-.557*	-.372*	-.483*	-.506*	-.672*

* Significant at < .05 level

Table 6

Results of Final Regression Equations

		TOTAL		URBAN		RURAL	
		Instrumental Care	Mothering	Instrumental Care	Mothering	Instrumental Care	Mothering
Model 1*	(R)	.558	.496	.522	.496	.609	.505
	(R^2)	(30.5%)	(24.6%)	(27.2%)	(24.6%)	(37.1%)	(25.5%)
		Marital Status, Education, Baby Physical.	Education, Marital Status	Baby Physical	Prenatal, Income	Education, Attitude toward Preventive Care	Education
Model 2**	(R)	.721	.764	.713	.759	.742	.822
	(R^2)	(52.0%)	(58.3%)	(50.8%)	(57.7%)	(55.1%)	(67.5%)
		Emotional/ Cognitive, Physical Care, Marital Status	Emotional/ Cognitive, Personality, Education	Emotional/ Cognitive, Physical, Income	Emotional/ Cognitive, Income	Education	Emotional/ Cognitive, Personality, Mother's Physical

*Model 1: Using all variables listed in Table 5 except appraisal scores.
**Model 2: Adding the appraisal scores to Model 1.

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Appendix A

Zero Order Correlation Matrix

TOTAL SAMPLE

VARIABLE NO. NO. NAME	1 URBAN RURAL	2 BABY PHYSICAL	3 MOTHER PHYSICAL	4 PRENATAL CARE	5 EDUCATION	6 INCOME	7 MARITAL STATUS	8 LIVING CHILDREN	9 GOOD INSTRUC- TIONAL CARE	10 MOTHERING	11 SOCIAL INTECHATION	12 ATTITUDE PREVENTIVE	13 PHYSICAL EN 1	14 PHYSICAL CARE 2	15 EMOTIONAL CARE 3	16 PERSON- ALITY 4
1 URBRUR	1.000															
2 BABYPHYS	-.081	1.000														
3 MOTHPHYS	-.141	.009	1.000													
4 PRENATAL	-.096	.048	.266	1.000												
5 EDUC	.135	-.078	.032	-.127	1.000											
6 INCOME	.023	-.018	-.178	.072	.297	1.000										
7 MARRSTAT	.371	-.053	-.113	-.098	.287	.488	1.000									
8 LIVCHILD	-.054	.078	-.051	.190	-.138	.096	.105	1.000								
9 GOODCARE	.385	-.204	-.126	-.154	.365	.291	.423	-.089	1.000							
10 MOTHRING	.248	-.046	-.120	-.163	.356	.285	.361	-.002	.803	1.000						
11 SOCINTRO	.165	.009	-.089	-.052	.326	.038	.202	-.008	.246	.249	1.000					
12 ATTPREV	-.045	-.142	-.090	-.155	.095	.107	.037	-.066	.147	.151	.068	1.000				
13 PHYSI	-.225	.108	-.052	.200	-.359	-.076	-.262	.214	-.551	-.500	-.317	-.073	1.000			
14 TRIFREDU	-.234	.253	.124	.176	-.216	-.033	-.257	.103	-.539	-.474	-.271	-.188	.624	1.000		
15 HANDSTMJ	-.169	.059	.051	.161	-.198	-.040	-.215	.027	-.523	-.440	-.250	-.175	.511	.575	1.000	
16 RSAQ	-.167	.038	.018	.131	-.255	-.187	-.175	.080	-.431	-.557	-.268	-.118	.463	.466	.482	1.000

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